## Appendix 14
## Removable Prosthodontic Services

| Proc. Code | Description of Service | PA Required? | Allowable Age | Limitations |
|---|---|---|---|---|
| ***Complete Dentures (including routine post-delivery care):*** | | | | |
| **05110** | Complete denture - maxillary | Yes | All | Allowed once per five years.***@ |
| **05120** | Complete denture - mandibular | Yes | All | Allowed once per five years.***@ |
| ***Partial Dentures (including routine post-delivery care):*** | | | | |
| **05211** | Maxillary partial denture - resin base (including any conventional clasps, rests, and teeth) | Yes | All | Allowed once per five years.***@ |
| **05212** | Mandibular partial denture - resin base (including any conventional clasps, rests, and teeth) | Yes | All | Allowed once per five years.***@ |
| **W7127** | Upgraded upper partial denture (including any conventional clasps, rests, and teeth) | Yes | All | Allowed once per five years.***@<br><br>*No dentist is obligated to provide this service.* |
| **W7128** | Upgraded lower partial denture (including any conventional clasps, rests, and teeth) | Yes | All | Allowed once per five years.***@<br><br>*No dentist is obligated to provide this service.* |
| ***Repairs to Complete Dentures:*** | | | | |
| **05510** | Repair broken complete denture base | No | All | Combined maximum reimbursement limit per six months for repairs.<br><br>Requires modifier (UU=Upper, LL=Lower). |

**Key:**

*** - Frequency limitation may be exceeded in exceptional circumstances.

@ - Healing period of six weeks required after last extraction prior to taking impressions for dentures, unless shorter period approved in prior authorization.

## Appendix 14
## Removable Prosthodontic Services
(continued)

| Proc. Code | Description of Service | PA Required? | Allowable Age | Limitations |
|---|---|---|---|---|
| **05520** | Repair missing or broken teeth - complete denture (each tooth) | No | All | Combined maximum reimbursement limit per six months for repairs.<br><br>Requires modifier (UU=Upper, LL=Lower.) |
| ***Repairs to Partial Dentures:*** | | | | |
| **05610** | Repair resin denture base | No | All | Limited to once per day.<br><br>Combined maximum reimbursement limit per six months for repairs.<br><br>Requires modifier (UU=Upper, LL=Lower). |
| **05620** | Repair cast framework | No | All | Combined maximum reimbursement limit per six months for repairs. Requires modifier (UU=Upper, LL=Lower). |
| **05630** | Repair or replace broken clasp | No | All | Combined maximum reimbursement limit per six months for repairs. Requires modifier (UU=Upper, LL=Lower). |
| **05640** | Replace broken teeth - per tooth | No | All | Combined maximum reimbursement limit per six months for repairs. Requires modifier (UU=Upper, LL=Lower). |
| **05650** | Add tooth to existing partial denture | No | All | Combined maximum reimbursement limit per six months for repairs. Requires modifier (UU=Upper, LL=Lower). |

**Key:**

*** - Frequency limitation may be exceeded in exceptional circumstances.

@ - Healing period of six weeks required after last extraction prior to taking impressions for dentures, unless shorter period approved in prior authorization.

## Appendix 14
## Removable Prosthodontic Services
(continued)

| Proc. Code | Description of Service | PA Required? | Allowable Age | Limitations |
|---|---|---|---|---|
| **05660** | Add clasp to existing partial denture | No | All | Combined maximum reimbursement limit per six months for repairs.<br><br>Requires modifier (UU=Upper, LL=Lower). |
| ***Denture Reline Procedures:*** | | | | |
| **05750** | Reline complete maxillary denture (laboratory) | Yes | All | Allowed once per three-year period.*** |
| **05751** | Reline complete mandibular denture (laboratory) | Yes | All | Allowed once per three-year period.*** |
| **05760** | Reline maxillary partial denture (laboratory) | Yes | All | Allowed once per three-year period.*** |
| **05761** | Reline mandibular partial denture (laboratory) | Yes | All | Allowed once per three-year period.*** |
| ***Maxillofacial Prosthetics:*** | | | | |
| **05932** | Obturator prosthesis, definitive | Yes | All | Allowed once per six months.*** |
| **05955** | Palatal lift prosthesis, definitive | Yes | All | Allowed once per six months.*** |
| **05999** | Unspecified maxillofacial prosthesis, by report | Yes | All | For medically necessary removable prosthodontic procedures not covered in Appendix 14.<br><br>Lab bills and narrative required. |

**Key:**

*** - Frequency limitation may be exceeded in exceptional circumstances.

@ - Healing period of six weeks required after last extraction prior to taking impressions for dentures, unless shorter period approved in prior authorization.

## Appendix 14
## Removable Prosthodontic Services
(continued)

### COVERED SERVICES

**FREQUENCY LIMITATIONS**

Removable prosthodontic services are limited to one new full or partial denture per five years unless unusual circumstances are documented with the prior authorization (PA) request.

**LIFE EXPECTANCY OF PROSTHESIS**

Generally, given reasonable care and maintenance, a prosthesis should last at least five years.

Unusual circumstances must be documented in the PA request to allow the DHFS to override the five-year limitation. Providers and recipients cannot expect to receive approval for a replacement prosthesis without adequate justification and documentation.

**DENTURE INSTRUCTIONS TO RECIPIENTS**

As part of any removable prosthetic service, dentists are expected to instruct the recipient on the proper care of the prostheses. Six months of post-insertion follow-up care is included for complete and partial dentures and relining complete and partial dentures.

**LOST, STOLEN, OR SEVERELY DAMAGED POLICY**

Removable prosthodontic services are provided at considerable program expense. Wisconsin Medicaid does not intend to repeatedly replace lost, severely damaged, or stolen prostheses. PA requests for lost, severely damaged, or stolen prostheses are only approved when:

- The recipient has exercised reasonable care in maintaining the denture.
- The prosthesis was being used up to the time of loss or theft.
- The loss or theft is *not* a repeatedly occurring event.
- A reasonable explanation is given for the loss or theft of the prosthesis.
- A reasonable plan to prevent future loss is outlined by the recipient or the facility where the recipient lives.

**HEALING PERIOD AFTER A TOOTH EXTRACTION**

The DHFS requires a minimum of six weeks healing after the last tooth extraction occurs before a final impression is made.

A PA request for dentures *can be approved before all teeth are removed*. The six-week healing period must still take place. *If the six-week waiting period does not take place, payment for dentures is denied or recouped.*

**SHORTER HEALING PERIOD AFTER TOOTH EXTRACTION**

A shorter healing period after an extraction may be approved or no healing period may be required if the PA request demonstrates that such approval is appropriate due to medical necessity, an unusual medical condition, that only a few teeth are extracted, or that extracted teeth are in noncritical areas such as the opposing arch.

Wisconsin Medicaid may grant a shortened healing period or require no healing period in limited situations for recipients who are employed with job duties that require public contact. In this situation, a statement from the employer indicating the job duties that require public contact must be included in the PA request.

To have a shorter healing period, a provider must request the shorter period at the same

## Appendix 14
## Removable Prosthodontic Services
(continued)

time the PA request for dentures is made.

**EDENTULOUS RECIPIENT**

If a recipient has been totally edentulous for more than five years and has never worn a prosthesis, then no denture is ordinarily approved unless the dentist submits:

- A favorable prognosis.
- An analysis of the oral tissue status (e.g., muscle tone, ridge height, muscle attachments, etc.).
- Justification indicating why a recipient has been without a prosthesis.

If a recipient has not worn an existing prosthesis for three years, no new prosthesis will usually be authorized unless unusual mitigating circumstances are documented and verified.

When a recipient has a history of an inability to tolerate and wear a prosthetic appliance due to psychological or physiological reasons, then a new prosthesis will not be approved.

### DENTURE REPAIR/RELINING COVERAGE

**REPAIR SERVICES**

Wisconsin Medicaid requests that dentists use discretion with denture repairs. Old, worn dentures with severely worn teeth or fractures due to age, should be replaced. A PA request with appropriate documentation must be submitted for replacement dentures.

**RELINING DENTURES**

Relining complete and partial upper and lower dentures is limited to once every three years. Six months of post-insertion follow-up care is included in reimbursement for complete and partial dentures and relining complete and partial dentures.

**COMPLETE DENTURE REPAIRS**

Complete denture repairs include:

- Repair of major fractures.
- Repair of broken flanges.
- Replacement of one or two lost denture teeth.

**PARTIAL DENTURE REPAIRS**

Repairs to damaged partial dentures include:

- Repair of fractured flanges.
- Repair of major fractures.
- Replacing a broken clasp with wrought wire clasps.
- Selective repair or addition of teeth.
- Adding teeth and/or a clasp to a partial denture if it makes the denture functional.

**NONCOVERED REPAIRS**

The following repairs are not covered by Wisconsin Medicaid:

- Extensive repairs of marginally functional dentures.
- Repairs to a denture when a new denture would be better for the health of the recipient.

## Appendix 14
## Removable Prosthodontic Services
(continued)

### PRIOR AUTHORIZATION

**PRIOR AUTHORIZED SERVICES**

*All removable prosthodontic services, except the repair of a denture, require PA.*

**MAXILLOFACIAL PROSTHESIS**

Palatal lifts prosthesis, obturators for cleft palate, and other maxillofacial prosthesis are covered services with PA. These services should be requested on the PA request in addition to a complete or removable partial denture when clinically appropriate.

**INITIAL DENTURES**

Providers should note that most PA requests for initial dentures are approved for *eligible* providers and recipients, *unless* the recipient cannot function with dentures due to a medical condition.

**FULL DENTURES WITH FEW REMAINING TEETH**

Wisconsin Medicaid will consider paying for full dentures when a recipient has only one or two remaining teeth per arch if this treatment would maintain proper anchorage and if the denture could be converted to a full denture by a simple repair in the event of tooth loss. The Medicaid dental consultant determines the appropriateness of this situation.

**PARTIAL DENTURES**

Partial dentures are covered only for recipients with good oral health and hygiene, good periodontal health (AAP type I or II), and a favorable prognosis where continuous deterioration of periodontal health is not expected. *Partial dentures are resin based.*

A recipient qualifies for a partial denture if the following criteria are met:

- One or more anterior teeth are missing.
- The recipient has less than two posterior teeth per quadrant in occlusion with the opposing quadrant.
- A combination of one or more anterior teeth are missing, and recipient has less than two posterior teeth per quadrant in occlusion with the opposing quadrant.
- The recipient can accommodate the partial and properly maintain the partial (e.g., no gag reflex, no potential for swallowing the partial, recipient not severely handicapped).
- AAP Type I or II.
- The recipient requires replacement of anterior teeth for employment reasons.
- Medically necessary for nutritional reasons documented by health history or physician.
- Unusual clinical situations where a partial is determined to be necessary based on a comprehensive review of the dental and medical histories.
- Good recipient attendance record.

If placement of a partial denture in an arch provides at least two posterior teeth (posterior teeth are bicuspids and molars only) per quadrant in occlusion with the opposing quadrant, then the opposing partial, if requested, would not be authorized unless recipient also has an anterior tooth missing in that arch.

Partial dentures can be granted to recipients needing partials for employment opportunities

## Appendix 14
## Removable Prosthodontic Services
(continued)

(refer to qualifications for partial).

**DOCUMENTATION**

Each PA request for removable prosthesis or relines should explain the individual needs of the recipient, and include the following information:

1. Complete and Partial Dentures.
   - The age of existing prosthesis (if applicable).
   - The date(s) of surgery or edentulation or verification.
   - The adaptability of the recipient. When appropriate, specifically document why a patient is not wearing an existing prosthesis, and why a new prosthesis will eliminate the problem.
   - Speech functions and phonetics documented by a speech therapist.
   - The appropriateness of repairing or relining the existing prosthesis or other alternative service.
   - Occlusal changes as vertical dimension.
   - Any misutilization practice of the recipient.
   - Documented loss or damage of prosthesis requiring replacement, if applicable, and how future loss will be prevented.

2. Partial Dentures
   - Complete periodontal charting and x-rays sufficient to show entire arch in question; the consultant can request additional information such as diagnostic casts on a case-by-case basis.
   - Periodontal status (AAP Type I-V).
   - Oral hygiene status.
   - Attendance record of recipient.
   - Verification that all abscessed or non-restorable teeth have been extracted or are scheduled to be extracted (or the PA request will be returned for extraction dates and appropriate healing period).
   - Verification that all remaining teeth are decay-free or the recipient is scheduled for all restorative procedures.
   - Success potential for proper completion and long-term maintenance of the partial denture.

The DHFS may request additional documentation including a *physician's* statement to verify:

- The medical necessity and appropriateness of the PA request.
- The prosthesis is necessary for proper nourishment and digestion.
- The recipient is physically and psychologically able to wear and maintain the prosthesis.
- The previous dentures have become unserviceable or lost.

## Appendix 14
## Removable Prosthodontic Services
(continued)

**DOCUMENTATION FOR LOST, STOLEN, OR SEVERELY DAMAGED DENTURES**

When submitting a PA request involving a lost, stolen, or severely damaged prosthesis, please give special attention to the need for the prosthesis. The request must include a police report, accident report, fire report, or hospital, nursing home, or group home (community-based residential facility) administrator statement or recipient statement on the loss. Such statements should include how, when, and where the prosthesis was lost or damaged, and what attempts were made to recover the loss and plans to prevent future loss.

**PALATAL LIFT PROSTHESIS DOCUMENTATION**

PA requests for palatal lift prostheses must include a speech pathologist's or physician's statement to document that a speech impediment exists.

**MAXILLOFACIAL PROSTHESIS DOCUMENTATION**

All maxillofacial prostheses require PA. Maxillofacial prostheses are approved based on medical necessity and appropriateness on a case-by-case basis.

**UPGRADED PARTIAL DENTURES DOCUMENTATION**

In response to requests by some dentists for coverage of higher quality partial dentures, Wisconsin Medicaid reimburses dentists for providing upgraded partial dentures. Due to fiscal limitations, and federal and state regulations, the following policy regarding these services has been established:

- PA is always required.
- Reimbursement is at the maximum fee for the "standard" resin-base partial denture.
- Reimbursement must be accepted as payment in full.
- Each dental office that provides the service must have written criteria based on medical necessity to determine who receives the upgraded service.
- The form in Appendix 25 of this handbook must be completed and attached to the Prior Authorization Dental Request Form (PA/DRF) and Prior Authorization Dental Attachment (PA/DA).
- All criteria must be applied consistently to all Medicaid recipients.

*No dentist is under any obligation to provide upgraded partial dentures.*

**TRAUMATIC LOSS OF TEETH FOR RECIPIENTS UNDER AGE 21**

When traumatic loss of one or more anterior teeth (tooth numbers 6-11, 22-27) occurs and partial dentures are required, a PA must be submitted.

**BACKDATING PRIOR AUTHORIZATION REQUESTS**

Where the service is identified as urgent in character, backdating the PA request to the date the request is received by the fiscal agent may be appropriate.

A request for backdating will be approved only if:

- The PA request specifically requests backdating.
- The clinical justification for beginning the service before PA is included.
- The request is received by the fiscal agent within 14 calendar days of the start of provision of services.

## Appendix 14
## Removable Prosthodontic Services
(continued)

### BILLING INFORMATION

**BILLING FOR PARTIAL AND COMPLETE DENTURES**

When billing for partial and complete dentures:

- Dentists are required to list the date that the final impressions were taken as the date of service.
- Recipients must be eligible on the date the final impressions are taken in order for the denture service to be covered. Providers will be asked to verify this date through progress notes if eligibility issues arise.

**REIMBURSEMENT FOR REPAIRS**

Wisconsin Medicaid reimburses a maximum amount per recipient, per denture, per six-month period for the repair of partial or complete dentures.

If laboratory costs exceed the maximum reimbursement allowed, dentists may submit a claim or adjustment request with laboratory bills.

### ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Medicaid-covered removable prosthodontic services, procedure codes, and related limitations.
- Appendix 31 for a summary of required billing documentation.
- Appendix 24 for a summary of required documentation needed for PA requests.

## Appendix 15
## Fixed Prosthodontic Services

*Please note that local anesthesia is included in the fee for procedures requiring anesthesia and is not separately billable. When a provider uses anesthesia, the anesthesia charge should be included in the amount billed for the procedure.*

| Proc. Code | Description of Service | PA Required? | Allowable Age | Limitations |
|---|---|---|---|---|
| ***Other Fixed Prosthetic Services:*** | | | | |
| **06545** | Retainer - cast metal for resin-bonded fixed prosthesis | Yes | All | Tooth numbers 1-32, SN only. |
| **06930** | Recement fixed partial denture | No | All | |
| **06940** | Stress breaker | Yes | All | Copy of lab bill required. |
| **06980** | Fixed partial denture repair, by report | Yes | All | Copy of lab bill required. |
| **W7310** | Fixed prosthodontic retainer | Yes | All | Tooth numbers 1-32, SN only. |
| **W7320** | Fixed prosthodontic pontic | Yes | All | Tooth numbers 1-32, SN only. |

## Appendix 15
## Fixed Prosthodontic Services
(continued)

### COVERED SERVICES

**DEFINITION**

Fixed prosthodontic services include fixed prosthodontic or acid etch retainers, pontics, repairing damaged fixed bridges, and permanently recementing fixed bridges.

The recementing of a fixed bridge, either of acid-etch retainer type or conventional crown/inlay/onlay retainers, is limited to permanent cementation.

### PRIOR AUTHORIZATION

**FIXED PROSTHODONTIC SERVICES**

Prior authorization (PA) is required for fixed bridge retainers, pontics, and acid etch retainers. Coverage is limited to recipients who cannot safely wear a removable partial denture due to a preexisting medical condition.

PA requests for fixed prosthetic services are only considered when the following criteria can be documented:

- The recipient cannot wear a removable partial or complete denture.
- The recipient has periodontally healthy teeth.
- The recipient has good oral hygiene.

**BRIDGE REPAIR**

Repairing a fixed bridge requires PA. The PA requests for the repair of a fixed prosthetic device are only considered when the following criteria can be documented:

- The fixed bridge is functional.
- The recipient has periodontally healthy teeth.
- The recipient has good oral hygiene.

**FIXED PROSTHODONTIC PRIOR AUTHORIZATION REQUEST DOCUMENTATION**

The following documentation must be submitted with a PA request for a fixed prosthodontic appliance:

- A minimum of periodontal charting and periapical radiographs of all abutment teeth.
- A periodontal status and oral hygiene status.
- An explanation of unsuccessful wearing or attempt to wear a removable prosthetic appliance.

If necessary, a study cast may be requested by Wisconsin Medicaid.

### ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Medicaid-covered fixed prosthodontic services, procedure codes, and related limitations.
- Appendix 31 for a summary of required billing documentation.
- Appendix 24 for a summary of required documentation needed for PA requests.

## Appendix 16
## Oral and Maxillofacial Surgery Services

*Please note that local anesthesia is included in the fee for procedures requiring anesthesia and is not separately billable. When a provider uses anesthesia, the anesthesia charge should be included in the amount billed for the procedure.*

| Proc. Code | Description of Service | PA Required? | Allowable Age | Limitations |
|---|---|---|---|---|
| ***Extractions (includes local anesthesia and routine postoperative care):*** | | | | |
| **07110** | Single tooth | No | All | Allowed only once per tooth (tooth numbers 1-32, A-T, SN).<br><br>Not billable same day as 07250. |
| ***Surgical Extractions (includes local anesthesia and routine postoperative care):*** | | | | |
| **07210** | Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth | No | All | Allowed only once per tooth.<br><br>Covered when performing an *emergency* service or with PA for orthodontia (tooth numbers 1-32, A-T, SN).[1]<br><br>Not billable same day as 07250. |
| **07220** | Removal of impacted tooth - soft tissue | No | All | Allowed only once per tooth. Covered when performing an *emergency service* or with PA for orthodontia (tooth numbers 1-32, A-T, SN).[1]<br><br>Not billable same day as 07250. |
| **07230** | Removal of impacted tooth - partial bony | No | All | Allowed only once per tooth. Covered when performing an *emergency service* or with PA for orthodontia (tooth numbers 1-32, A-T, SN).[1]<br><br>Not billable same day as 07250. |
| **07240** | Removal of impacted tooth - completely bony | No | All | Allowed only once per tooth. Covered when performing an *emergency service* or with PA for orthodontia (tooth numbers 1-32, A-T, SN).[1]<br><br>Not billable same day as 07250. |

**Key:**

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

## Appendix 16
## Oral and Maxillofacial Surgery Services
(continued)

| Proc. Code | Description of Service | PA Required? | Allowable Age | Limitations |
|---|---|---|---|---|
| **07250** | Surgical removal of residual tooth roots (cutting procedure) | No | All | *Emergency only* (tooth numbers 1-32, A-T, SN).[1]<br><br>Allowed only once per tooth.<br><br>Not allowed on the same day as tooth extraction of same tooth number. |
| ***Other Surgical Procedures:*** | | | | |
| **07260 or CPT[2]** | Oroantral fistula closure | No | All | |
| **07270** | Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus | No | All | *Emergency only* (tooth numbers 1-32, C-H, M-R, SN).[1] |
| **07280** | Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments) | Yes | < 21 | HealthCheck referral is required.<br><br>Not allowed for primary or wisdom teeth (tooth numbers 2-15, 18-31, SN only). |
| **07281** | Surgical exposure of impacted or unerupted tooth to aid eruption | Yes | < 21 | HealthCheck referral is required.<br><br>Not allowed for wisdom teeth (tooth numbers 2-15, 18-31, A-T, SN only). |
| **07285 or CPT[2]** | Biopsy of oral tissue - hard | No | All | Once per day.** |
| **07286 or CPT[2]** | Biopsy of oral tissue - soft | No | All | Once per day.** |

**Key:**

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

## Appendix 16
## Oral and Maxillofacial Surgery Services
(continued)

| Proc. Code | Description of Service | PA Required? | Allowable Age | Limitations |
|---|---|---|---|---|
| ***Removal of Tumors, Cysts, and Neoplasms:*** | | | | |
| **07430 or CPT[2]** | Excision of benign tumor - lesion diameter up to 1.25 cm | No | All | Once per day.** |
| **07431 or CPT[2]** | Excision of benign tumor - lesion diameter greater than 1.25 cm | No | All | Once per day.** |
| **07440 or CPT[2]** | Excision of malignant tumor - lesion diameter up to 1.25 cm | No | All | Pathology report required. |
| **07441 or CPT[2]** | Excision of malignant tumor - lesion diameter greater than 1.25 cm | No | All | Pathology report required. |
| **07450 or CPT[2]** | Removal of odontogenic cyst or tumor - lesion diameter up to 1.25 cm | No | All | Pathology report required. |
| **07451 or CPT[2]** | Removal of odontogenic cyst or tumor - lesion diameter greater than 1.25 cm | No | All | Pathology report required. |
| **07460 or CPT[2]** | Removal of nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm | No | All | Pathology report required. |
| **07461 or CPT[2]** | Removal of nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm | No | All | Pathology report required. |

**Key:**

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

## Appendix 16
## Oral and Maxillofacial Surgery Services
(continued)

| Proc. Code | Description of Service | PA Required? | Allowable Age | Limitations |
|---|---|---|---|---|
| ***Excision of Bone Tissue:*** | | | | |
| **07470 or CPT[2]** | Removal of exostosis - maxilla or mandible | Yes | All | Operative report required. |
| **07480 or CPT[2]** | Partial ostectomy (guttering or saucerization) | No | All | Operative report required. |
| **07490 or CPT[2]** | Radical resection of mandible with bone graft | No | All | Operative report required.<br><br>Only allowable in place of service 0, 1, 2, or B. |
| ***Surgical Incision:*** | | | | |
| **07510 or CPT[2]** | Incision and drainage of abscess - intraoral soft tissue | No | All | Operative report required.<br><br>Not to be used for periodontal abscess - use W7118. |
| **07520 or CPT[2]** | Incision and drainage of abscess - extraoral soft tissue | No | All | Operative report required. |
| **07530 or CPT[2]** | Removal of foreign body, skin, or subcutaneous areolar tissue | Yes, unless provided to hospital inpatient | All | Not allowed for root fragments or bone spicules.<br><br>Operative report required. |
| **07540 or CPT[2]** | Removal of reaction-producing foreign bodies - musculoskeletal system | Yes, unless provided to hospital inpatient | All | Not allowed for root fragments or bone spicules.<br><br>Operative report required. |
| **07550 or CPT[2]** | Sequestrectomy for osteomyelitis | No | All | Operative report required. |
| **07560 or CPT[2]** | Maxillary sinusotomy for removal of tooth fragment or foreign body | No | All | Operative report required. |

**Key:**

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

## Appendix 16
## Oral and Maxillofacial Surgery Services
(continued)

| Proc. Code | Description of Service | PA Required? | Allowable Age | Limitations |
|---|---|---|---|---|
| ***Treatment of Fracture - Simple:*** | | | | |
| **07610 or CPT[2]** | Maxilla - open reduction (teeth immobilized, if present) | No | All | Only allowable in place of service 0, 1, 2, 3, or B.<br><br>Operative report required. |
| **07620 or CPT[2]** | Maxilla - closed reduction (teeth immobilized, if present) | No | All | Operative report required. |
| **07630 or CPT[2]** | Mandible - open reduction (teeth immobilized, if present) | No | All | Only allowable in place of service 0, 1, 2, 3, or B.<br><br>Operative report required. |
| **07640 or CPT[2]** | Mandible - closed reduction (teeth immobilized, if present) | No | All | Only allowable in place of service 0, 1, 2, 3, or B.<br><br>Operative report required. |
| **07650 or CPT[2]** | Malar and/or zygomatic arch - open reduction | No | All | Only allowable in place of service 0, 1, 2, 3, or B.<br><br>Operative report required. |
| **07660 or CPT[2]** | Malar and/or zygomatic arch - closed reduction | No | All | Only allowable in place of service 0, 1, 2, 3, or B.<br><br>Operative report required. |
| **07670 or CPT[2]** | Alveolus - stabilization of teeth, open reduction splinting | No | All | Operative report required. |
| **07680 or CPT[2]** | Facial bones - complicated reduction with fixation and multiple surgical approaches | No | All | Only allowable in place of service 0, 1, 2, 3, or B.<br><br>Operative report required. |

**Key:**

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

## Appendix 16
## Oral and Maxillofacial Surgery Services
(continued)

| Proc. Code | Description of Service | PA Required? | Allowable Age | Limitations |
|---|---|---|---|---|
| ***Treatment of Fractures - Compound:*** | | | | |
| **07710 or CPT[2]** | Maxilla - open reduction | No | All | Only allowable in place of service 0, 1, 2, 3, or B.<br><br>Operative report required. |
| **07720 or CPT[2]** | Maxilla - closed reduction | No | All | Only allowable in place of service 0, 1, 2, 3, or B.<br><br>Operative report required. |
| **07730 or CPT[2]** | Mandible - open reduction | No | All | Only allowable in place of service 0, 1, 2, 3, or B.<br><br>Operative report required. |
| **07740 or CPT[2]** | Mandible - closed reduction | No | All | Only allowable in place of service 0, 1, 2, 3, or B.<br><br>Operative report required. |
| **07750 or CPT[2]** | Malar and/or zygomatic arch - open reduction | No | All | Only allowable in place of service 0, 1, 2, 3, or B.<br><br>Operative report required. |
| **07760 or CPT[2]** | Malar and/or zygomatic arch - closed reduction | No | All | Only allowable in place of service 0, 1, 2, 3, or B.<br><br>Operative report required. |
| **07770 or CPT[2]** | Alveolus - stabilization of teeth, open reduction splinting | No | All | Only allowable in place of service 0, 1, 2, 3, or B.<br><br>Operative report required. |
| **07780 or CPT[2]** | Facial bones - complicated reduction with fixation and multiple surgical approaches | No | All | Only allowable in place of service 0, 1, 2, 3, or B.<br><br>Operative report required. |

**Key:**

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

## Appendix 16
## Oral and Maxillofacial Surgery Services
(continued)

| Proc. Code | Description of Service | PA Required? | Allowable Age | Limitations |
|---|---|---|---|---|
| ***Reduction of Dislocation and Management of Other TMJ Dysfunctions:*** | | | | |
| **07810 or CPT[2]** | Open reduction of dislocation | No | All | Only allowable in place of service 0, 1, 2, 3, or B.<br><br>Operative report required. |
| **07820 or CPT[2]** | Closed reduction of dislocation | No | All | Once per day.** |
| **07830 or CPT[2]** | Manipulation under anesthesia | No | All | Only allowable in place of service 0, 1, 2, 3, or B.<br><br>Operative report required. |
| **07840 or CPT[2]** | Condylectomy | Yes | All | Multidisciplinary TMJ evaluation required.<br><br>Only allowable in place of service 1, 2, or B. No operative report required. |
| **07850 or CPT[2]** | Surgical discectomy; with/without implant | Yes | All | Multidisciplinary TMJ evaluation required.<br><br>Only allowable in place of service 1, 2, or B. No operative report required. |
| **07860 or CPT[2]** | Arthrotomy | Yes | All | Multidisciplinary TMJ evaluation required.<br><br>Only allowable in place of service 1, 2, or B. No operative report required. |
| **W7995** | Initial consultation, TMJ (TMJ multi-disciplinary evaluation program use only) | No | All | Multidisciplinary TMJ evaluation required.<br><br>Only allowable in place of service 1, 2, or B. No operative report required. |
| **W7996** | Follow-up consultation, TMJ (TMJ multidisciplinary evaluation program use only) | No | All | Allowed once per year, per multidisciplinary TMJ evaluation program. Allowable in place of service 1, 2, or 3. |

**Key:**

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

## Appendix 16
## Oral and Maxillofacial Surgery Services
(continued)

| Proc. Code | Description of Service | PA Required? | Allowable Age | Limitations |
|---|---|---|---|---|
| **W7998 or CPT[2]** | TMJ assistant surgeon | Yes | All | Procedure must be included in PA request for the surgery itself.<br><br>Only allowable in place of service 1, 2, or B. |
| ***Repair of Traumatic Wounds:*** | | | | |
| **07910 or CPT[2]** | Suture of recent small wounds up to 5 cm | No | All | *Emergency only* - operative report required. |
| ***Complicated Suturing (reconstruction requiring delicate handling of tissues and wide undermining for meticulous closure):*** | | | | |
| **07911 or CPT[2]** | Complicated suture - up to 5 cm | No | All | Covered for *trauma (emergency) situations only.*[1]<br><br>Operative report required. |
| **07912 or CPT[2]** | Complicated suture - greater than 5 cm | No | All | Covered for *trauma (emergency) situations* only.[1] Once per day.**<br><br>No operative report required, unless same day as surgery. |
| ***Other Repair Procedures*** | | | | |
| **07940 or CPT[2]** | Osteoplasty - for orthognathic deformities | Yes | < 21 | HealthCheck referral required.<br><br>Only allowable in place of service 1, 2, or B. No operative report required. |
| **07950 or CPT[2]** | Osseous, osteo-periosteal, or cartilage graft of the mandible or facial bones - autogenous or nonautogenous, by report | Yes | All | Multidisciplinary TMJ evaluation required.<br><br>Only allowable in place of service 1, 2, 3, or B. No operative report needed. |

**Key:**

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

## Appendix 16
## Oral and Maxillofacial Surgery Services
(continued)

| Proc. Code | Description of Service | PA Required? | Allowable Age | Limitations |
|---|---|---|---|---|
| **07960 or CPT[2]** | Frenulectomy (frenectomy or frenotomy) - separate procedure | Yes | < 21 | HealthCheck referral required.<br><br>No operative report needed. |
| **07970 or CPT[2]** | Excision of hyperplastic tissue - per arch | Yes | All | No operative report needed. |
| **07980 or CPT[2]** | Sialolithotomy | No | All | Only allowable in place of service 0, 1, 2, 3, or B.<br><br>Operative report required. |
| **07991 or CPT[2]** | Coronoidectomy | Yes | All | Multidisciplinary TMJ evaluation required.<br><br>Only allowable in place of service 1, 2, or B. No operative report needed. |
| **07999 or CPT[2]** | Unspecified oral surgery procedure, by report | Yes | All | For medically necessary oral and maxillofacial procedures not included in Appendix 16.<br><br>Does not include alveoplasty, vestibuloplasty, or other procedures not covered by Wisconsin Medicaid.<br><br>Operative report required. |

**Key:**

[1] - Retain records in recipient files regarding nature of emergency.

[2] - Providers who are Wisconsin Medicaid certified as oral surgeons or oral pathologists or choose CPT billing must use a CPT code to bill for this procedure. Refer to Appendix 19 for a list of covered CPT procedure codes.

** - Frequency limitation may be exceeded if a narrative on the claim demonstrates medical necessity for additional services.

## Appendix 16
## Oral and Maxillofacial Surgery Services
(continued)

**ORAL AND MAXILLOFACIAL SURGERY EXCEPT TMJ**

### COVERED SERVICES

**DEFINITION**

Wisconsin Medicaid may cover oral and maxillofacial surgical services due to trauma or congenital malformations such as clefts, or the removal of pathologic, painful, or non-restorable teeth. Corrective congenital surgery, such as orthognathic surgery, is limited to specific cases due to severe handicapping malocclusions.

**SURGICAL EXTRACTION OF A TOOTH**

Surgical extraction of a tooth is covered only when an extraction is necessary due to:

- An emergency which is a situation when an immediate service must be provided to relieve the recipient from pain, an acute infection, swelling, fever, or trauma.
- Orthodontia (for children up to age 21). In this case, prior authorization (PA) should be requested for the surgical extraction of a tooth in a non-emergency situation.

If during the routine extraction of any tooth the extraction unexpectedly becomes a surgical extraction, the surgical extraction is considered a dental emergency and will be covered. The procedure should be billed as an emergency and documentation of the circumstances must be kept in the recipient's records.

**REPLANTATION AND SPLINTING**

The replantation and splinting of a traumatically avulsed or subluxated tooth:

- Includes the post-operative follow-up.
- Includes the removal of any splints and wires.
- *Does not include any root canal therapy for the involved teeth.*

**SUTURING**

Suturing is:

- A covered benefit only when it is a result of a trauma.
- Not separately reimbursable when it is part of the surgery. In this case, it is included in the surgical procedure and fee.

When billing for suturing, the provider must include an operative report accurately describing the procedure, complexity of closure, location of laceration, and length of laceration(s) repaired.

### PRIOR AUTHORIZATION

**GENERAL INFORMATION**

A study model may be requested by the dental consultant to aid in evaluating any PA request.

**SURGICAL EXPOSURE OF AN IMPACTED OR UNERUPTED TOOTH**

The surgical exposure of an impacted or unerupted tooth for orthodontic reasons includes placement of any hooks, wires, pins, etc., to aid eruption through orthodontics. This service includes placement of any orthodontic appliance on the impacted tooth.

## Appendix 16
## Oral and Maxillofacial Surgery Services
(continued)

The documentation required for submitting the PA request is:

- A HealthCheck exam (the HealthCheck provider signature is required).
- A periapical radiograph of the tooth.

**SURGICAL EXPOSURE OF A TOOTH TO AID ERUPTION**

For the surgical exposure of a tooth to aid eruption, the tooth must be impacted by an adjacent tooth and not close to natural eruption. This service can be requested for primary and permanent teeth.

This service does *not* include placement of any hooks, wires, pins, etc., to aid eruption through orthodontics.

The documentation required for submitting the PA request is:

- A HealthCheck referral.
- A periapical radiograph of the tooth.

**REMOVAL OF EXOSTOSIS MAXILLAE OR MANDIBLE**

Criteria for PA approval include one of the following:

- The exostosis presents an undesirable undercut.
- The exostosis presents problems with insertion or stability of prosthesis.
- Medically necessary due to the presence of pain caused by the insertion or wearing of a removable prosthesis.

**REMOVAL OF FOREIGN BODY**

Removal of foreign body requires one periapical x-ray to accompany the PA request.

**OSTEOPLASTY/ OSTEOTOMY**

Osteoplasty/osteotomy for orthognathic deformities is provided for only the most severe orthodontic skeletal malocclusion. PA requests for correction of orthognathic deformities require a HealthCheck referral. Criteria for approval include one of the following:

- To correct the most severe cases of protruding or retruding mandible or maxillae where conventional orthodontics cannot provide a stable and acceptable outcome.
- To correct the most severe cases of open bite where conventional orthodontics cannot provide a stable and acceptable outcome.
- To correct a significant skeletal malocclusion where conventional orthodontics cannot provide a stable and acceptable outcome.
- To correct severe malocclusions caused by disease or injury where conventional orthodontics cannot provide a stable and acceptable outcome.

If the deformity has been caused by disease or injury, a physician's statement is required.

A HealthCheck referral is required for PA approval. The criteria for approval include a frenum which creates a central incisor diastema, ankyloglossia, periodontal defects, removable prosthodontic impairment, or is necessary to complete orthodontic services.

## Appendix 16
## Oral and Maxillofacial Surgery Services
(continued)

**EXCISION OF HYPERPLASTIC TISSUE**

For the excision of hyperplastic tissue (per arch), the recipient must have an edentulous ridge and have difficulty wearing a prosthesis. The recipient must have adequate healing after tooth extraction before requesting this service. The service includes all local anesthetic, suturing, post-operative care, and soft tissue conditioning of any appliances at the time of surgery.

### TMJ SURGERY

**DEFINITION**

The TMJ office visit requires detailed and extensive examination and documentation of the recipient's TMJ dysfunction.

A TMJ office visit consists of:

- A comprehensive history.
- Clinical examination.
- Diagnosis.
- Treatment planning.

**INITIAL TREATMENT**

The initial treatment of a TMJ dysfunction must consist of non-surgical treatments which include:

- Short-term medication.
- Home therapy (e.g., soft diet).
- Splint therapy.
- Physical therapy, including correction of myofunctional habits.
- Relaxation or stress management techniques.
- Psychological evaluation or counseling.

*The non-surgical TMJ treatments are not covered by Wisconsin Medicaid.*

**EVALUATION FOR TMJ SURGERY**

When non-surgical TMJ therapy has failed to reduce TMJ dysfunction and pain, the recipient may request TMJ surgery. An oral and maxillofacial surgeon or physician surgeon can submit a PA request for TMJ surgery. The request must include an evaluation by a Department of Health and Family Services (DHFS)-approved Multidisciplinary TMJ Evaluation Program. A listing of the approved TMJ multi-disciplinary evaluation program sites is in Appendix 6 of this handbook. The initial TMJ consultation can be billed by the dentist performing the dental evaluation component of the evaluation program.

A follow-up consultation may be billed if necessary to clarify or review the findings and conclusions of the initial consultation.

## Appendix 16
## Oral and Maxillofacial Surgery Services
(continued)

This evaluation must be provided by a facility not previously involved with the treatment of the recipient. The multi-disciplinary evaluation includes:

- A dental evaluation conducted by an oral and maxillofacial surgeon, orthodontist, or general practice dentist.
- A physical evaluation conducted by a neurologist, psychiatrist, or other physician knowledgeable regarding TMJ therapies.
- A psychological evaluation conducted by a psychiatrist or psychologist.

### PRIOR AUTHORIZATION

**TMJ EVALUATION**

Documentation of the evaluation conclusions (including dentist's and physician's) must be included when the PA request is being submitted. All PA requests submitted for TMJ surgery must include a second opinion evaluation by a DHFS-approved multidisciplinary center. A PA request received without a multi-disciplinary evaluation will be returned. Only TMJ surgeries with favorable prognosis for surgery are considered for approval.

To adequately provide a second opinion, the multidisciplinary center must have the necessary dental records on hand before seeing the recipient. The following materials must be at the second opinion location *before* the recipient's consultation visit:

- Any imaging procedures completed (MRI reports, x-rays, etc.).
- Operative notes addressing symptoms, findings, and diagnosis.
- Documentation of conservative care performed, including any occupational or physical therapy notes.
- Operative plan.
- Three to six-month postoperative plan of care.

**TMJ CRITERIA FOR APPROVAL**

PA criteria for approval include:

- Documentation of American Association of Oral and Maxillofacial Surgeries criteria.
- Documentation of second opinion.
- Favorable prognosis for surgery verified by second opinion.

### ALL ORAL AND MAXILLOFACIAL SURGERY SERVICES BILLING

**PRE- AND POST-CARE DAYS**

Reimbursement for procedures directly related to an oral surgery is incorporated into reimbursement for the oral surgery procedure.

Palliative treatment, application of desensitizing medicaments, and other related procedures are not allowed at least three days before and 10 or more days after the surgery. Other procedures that are directly related to the surgery are not to be billed separately, no matter when the procedure is billed.

## Appendix 16
## Oral and Maxillofacial Surgery Services
(continued)

However, if the procedure is not directly related to oral surgery, the limitation can be overridden with a narrative demonstrating that fact on the claim form. For example, the procedure may be done on a separate section of the mouth than the oral surgery.

**ONE PER DAY LIMITATION**

Many oral surgeries are limited to once per day. This limitation may be exceeded if narrative on the claim form demonstrates the additional services were medically necessary.

**ADA/CPT ORAL SURGERY BILLING OPTIONS**

Medicaid-certified dentists can select the procedure coding system they want to use for billing all oral surgery codes that do not require a tooth letter or number. Dentists can select either:

- The American Dental Association (ADA) Current Dental Terminology.
- The *Physicians' Current Procedural Terminology* (CPT).

The narrative below outlines the way that oral surgery procedure code billing is automatically assigned to dentists and provides an opportunity for dentists to choose a different billing system than they are assigned.

**ASSIGNMENT OF ORAL SURGERY BILLING**

Assignment of oral surgery billing depends on the dental specialty chosen during Medicaid certification. This assignment is necessary because it provides the fiscal agent's computers both a systematic way to identify the oral surgery procedure codes a provider can bill and a way to ensure accurate reimbursement.

**SPECIALTIES BILLING CPT**

This means that dentists with the following specialties are required to bill CPT procedure codes for oral surgeries that do not require tooth modifiers:

- Oral surgeons.
- Oral pathologists.
- Other dentists who indicate they want to bill CPT codes (using the form in Appendix 2 of this handbook).

**SPECIALTIES BILLING ADA**

The following specialties are required to bill ADA procedure codes for all oral surgeries:

- Endodontic.
- Orthodontics.
- Periodontics.
- Oral surgeons/pathologists who indicate they want to use ADA codes (using the form in Appendix 2 of this handbook).
- General practice.
- Pedodontics.
- Prosthodontics.

The chart in Appendix 2 of this handbook provides further clarification of this policy.

**CHOOSING DIFFERENT BILLING**

Any dentist who wants to elect a different billing specialty than currently chosen may do so by completing the form in Appendix 2 of this handbook.

## Appendix 16
## Oral and Maxillofacial Surgery Services
(continued)

**MD/DDS**

When a provider is licensed as both a D.D.S. and M.D., Wisconsin Medicaid encourages the provider to enroll as a dentist (provider type 27 - oral surgery specialty 041).

**IDENTICAL POLICIES AND REIMBURSEMENT FOR ALL DENTISTS**

All dentists, regardless of specialty:

- Receive the same reimbursement for the same procedures.
- Have virtually the same program limitations, such as PA requirements, for the same procedures.
- Will bill all other dental (non-surgical) procedures using ADA procedure codes and a few Wisconsin Medicaid HCPCS local procedure codes (W codes).
- Must bill for all oral surgeries using the code system assigned at certification or chosen by completing the attached form.
- Cannot temporarily alternate between coding systems, using different procedure codes on different days.
- Can change their designated coding system anytime by completing the attached form.
- Will find that CPT billing requires fewer attachments and is easier to bill electronically.

**DECREASED ATTACHMENTS AND CLAIMS PROCESSING TIME**

The CPT coding system is more precise than the ADA coding system for describing the same oral surgery procedures. Therefore, most CPT codes do not require operative and pathology reports for manual pricing by the Medicaid dental consultant as well as the additional time needed for processing manually priced claims. This will facilitate electronic billing.

### ORAL SURGERY BILLING USING ADA PROCEDURE CODES

**ADA PROCEDURE CODES**

The ADA and local HCPCS oral surgery procedure codes that are covered by Wisconsin Medicaid are listed in Appendix 16 of this handbook.

**WISCONSIN MEDICAID CLAIM FORM**

When ADA and HCPCS codes are used to bill Wisconsin Medicaid, the ADA claim form must be used.

**ASSISTING SURGEON**

Dentists billing ADA procedure codes will need to bill for the assisting surgeon as follows:

- If a procedure requires PA and an assisting surgeon will be used, request approval for both at the same time.
- Use the prior authorized TMJ assisting surgeon code (W7998) for TMJ surgery.
- With PA, surgical assistance may be paid under procedure code 07999.

### ORAL SURGERY BILLING USING CPT PROCEDURE CODES FOR PROCEDURES THAT ARE NOT TOOTH SPECIFIC

**CPT PROCEDURES**

Appendix 19 of this handbook contains a complete list of all the CPT procedure codes that are covered in Wisconsin Medicaid dental benefit. Oral surgeons, oral pathologists, and dentists electing CPT billing use these codes instead of the ADA oral surgery codes that do not require tooth modifiers.

## Appendix 16
## Oral and Maxillofacial Surgery Services
(continued)

**HCFA 1500**

The HCFA 1500 claim form must be used when using a CPT procedure code for billing. If a dentist provides both ADA and CPT procedures for a single patient, both may be billed on the HCFA 1500 claim form. The only ADA codes that cannot be billed on the HCFA 1500 claim form are restorative codes that require tooth surface information. Appendix 29 of this handbook contains HCFA 1500 billing instructions.

**DIAGNOSIS**

An *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code is always required in element 21 when using CPT codes on the HCFA 1500 claim form.

**ASSISTING SURGEON**

An assisting surgeon is allowed for some complex surgery procedures as noted on the chart in Appendix 19 of this handbook. To bill for an assisting surgeon, put the modifier "80" in element 24I of the HCFA 1500. If a procedure requires PA and an assisting surgeon will be used, request approval for both at the same time.

**TMJ SURGERY PROCEDURES AND MANAGED CARE PROGRAMS**

Medicaid-contracted managed care programs that cover dental services are responsible for providing a multidisciplinary evaluation at a facility of their choice to determine the necessity of TMJ surgery. If the surgery is approved, the managed care program may designate the facility at which the surgery is performed. The managed care program is responsible for paying the cost of the surgery and all related services (e.g., hospitalization, anesthesiology).

Wisconsin Medicaid does not reimburse for a TMJ surgery billed by a dentist on a fee-for-service basis when provided to a Medicaid recipient enrolled in a Medicaid-contracted managed care program which covers dentistry. Therefore, dentists must participate in or obtain a referral from the recipient's managed care program since the managed care program is responsible for paying the cost of all services. Failing to obtain a managed care program referral may result in a denial of payment for services by the managed care program. Refer to the Wisconsin Medicaid Managed Care Guide for more information.

If a Medicaid-contracted managed care program does *not* cover dental services, the multidisciplinary evaluation must be performed at a multidisciplinary evaluation facility designated by the DHFS. The dentist may submit a PA request to the fiscal agent and, if approved, the dental surgeon is reimbursed for the evaluation on a fee-for-service basis.

- Refer to the Wisconsin Medicaid Managed Care Guide and Appendices 20, 21, and 22 of Part A, the all-provider handbook, for a list of Medicaid-contracted managed care programs and services that can be billed fee-for-service.
- If surgery is recommended and the PA is approved, the managed care program is responsible for paying the cost of all related medical and hospital services and may therefore designate the facility at which the surgery is performed.
- The dentist must work closely with the managed care program to ensure continuity of coverage.

## Appendix 16
## Oral and Maxillofacial Surgery Services
(continued)

**EMERGENCY SERVICES**

*Emergency services are defined as services that must be provided immediately to relieve pain, swelling, acute infection, trismus, or trauma. Because the ADA claim form does not have an element to designate emergency treatment, all claims for emergency services must be identified by an "E"* in the "For Administrative Use Only" box on the line item for the emergency service of the ADA claim form or element 24I of the HCFA 1500 claim form in order to exempt the services from copayment deduction. *Only the letter "E" without any additional letters is accepted*. Information relating to the definition of a dental emergency is in Section II-A of this handbook.

EMC claims use a different field to indicate an emergency. Refer to your EMC manual for more information.

### ADDITIONAL INFORMATION

In addition to this summary, refer to:

- The preceding pages for a complete listing of Medicaid-covered oral and maxillofacial surgery services, procedure codes, and related limitations.
- Appendix 31 of this handbook for a summary of required billing documentation.
- Appendix 24 of this handbook for a summary of required documentation needed for PA requests.